

471-000-506 Nebraska Medicaid Practitioner Fee Schedule for Dental Services

Note: Prior to using information provided in this fee schedule, review the following on-line tools for the latest in Dental policy and billing guidance:

Dental Provider Handbook: http://dhhs.ne.gov/medicaid/Pages/med_phden.aspx

Provider Information: http://dhhs.ne.gov/medicaid/Pages/med_provhme.aspx

Provider Bulletins: <http://www.dhhs.ne.gov/med/pb/>

Client Eligibility: Call the NMES Line at 1-800-642-6092 for client's Medicaid eligibility
http://dhhs.ne.gov/medicaid/Pages/med_eligibility.aspx

Claim Inquiries: Call the Inquiry Line, 1-877-255-3092, please have your claim number ready.

Claims Processing: http://dhhs.ne.gov/medicaid/Pages/med_claimsfaq.aspx

This fee schedule does not address the various coverage limitations routinely applied by Nebraska Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third part liability, age restrictions, prior authorization, co-payments/coinsurance where applicable, etc.). Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.

Although every effort is made to ensure the accuracy of this information, discrepancies and time lag may occur. All information may be changed or updated at any time to correct a discrepancy and/or error. The reimbursement rates reflected in this fee schedule are in effect as of the date of this report. The reimbursement rate made on a claim will depend on the date of service, since reimbursement rates are date of service effective.

For billing instructions for Dental Services, please see <http://dhhs.ne.gov/Documents/471-000-88.pdf> and the appendices as well provider bulletins in the Dental Provider Handbook.

Nebraska Medicaid payment is the lower of the fee schedule allowable or the provider's submitted charge(s). The provider's submitted charge(s) must reflect their charge to the general public. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Please refer to description, coverage criteria/limitations for certain dental procedure codes.

Definitions:

*"BR" (By Report) – Paid at "reasonable charge" based on the service and circumstances. A complete description of the service (and additional documentation, if applicable) is required for review. The provider's submitted charge must reflect their charge to the general public.

*FEE DETERMINED BY TREATMENT PLAN – Paid at Medicaid prior authorized amount based on the services authorized. A complete description of the services/treatment to be provided is required for prior authorization review. The provider's submitted charge on the prior authorization request must reflect their charge to the general public.

*PA (Prior Authorization) – Certain services require prior authorization, which includes a completed ADA form with the code/codes requested for review.

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|--------------------|---|-------------------|-------------------|--|
| D0120 | Periodic oral evaluation | \$21.20 | No | <p><u>Age 20 & Younger:</u> Routine periodic oral evaluation are covered every 6 months Can be seen more frequently if determined necessary by treating dentist.</p> <p><u>Age 21 & Older:</u> Routine periodic oral evaluation are covered 1 time every 12 months.</p> <p><u>Age 21 & Older with Special Needs:</u> Routine periodic oral evaluation are covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition or a pregnant woman.</p> |
| D0140 | Limited oral evaluation – problem focused | \$21.44 | No | <p>An evaluation limited to a specific oral health problem or complaint. Report additional diagnostic procedures separately.</p> <p>Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.</p> |
| D0145 | Oral evaluation for a patient under 3 years of age & counseling with primary caregiver | \$35.50 | No | |
| D0150 | Comprehensive oral evaluation – new or established patient | \$20.88 | No | <p><u>Note - All Clients</u> Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists.</p> |
| D0160 | Detailed and extensive oral evaluation – problem focused, by report | \$27.00 | No | |
| D0170 | Re-evaluation – limited, problem focused (established patient; not post-operative visit | \$16.00 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|--------------------|---|-------------------|-------------------|--|
| D0180 | Comprehensive periodontal evaluation – new or established patient | \$27.00 | No | |
| D0210 | Intraoral – complete series of radiographic images(including bitewings) | \$45.00 | No | Maximum payment of \$45.00 per date of service for any combination of codes D0210 – D0330. |
| D0220 | Intraoral – periapical first radiographic image | \$6.00 | No | |
| D0230 | Intraoral – periapical each additional radiographic image | \$5.00 | No | |
| D0240 | Intraoral – occlusal radiographic (2 ¼ x 3 ¼ size) | \$7.00 | No | D0240 occlusal film is 2 ¼ x 3 ¼ size. |
| D0270 | Bitewing – single radiographic-image | \$9.00 | No | Bitewings – maximum of 4 per date of service. |
| D0272 | Bitewings – two radiographic images | \$13.00 | No | |
| D0273 | Bitewings – three radiographic images | \$15.00 | No | Intraoral – complete series – covered every three years |
| D0274 | Bitewings – four radiographic images | \$19.00 | No | |
| D0330 | Panoramic radiographic image | \$36.00 | No | Panoramic film – covered every 3 years on a routine basis. Covered more frequently if necessary for treatment. |
| D0340 | Cephalometric radiographic image | \$62.00 | No | Covered for clients age 20 and younger for diagnosis if treating dentist believes through visual exam that the client may qualify for Medicaid coverage of orthodontic treatment (see 471 NAC 6-005 page 11 of 14) |
| D0470 | Diagnostic casts | \$46.00 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|-------------|---|------------|------------|---|
| D1110 | Prophylaxis – adult (age 14 and older) | \$31.00 | No | <p><u>Age 14 through Age 20:</u> Covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered the standard BILL ON CODE D1110.</p> <p><u>Age 21 & Older:</u> Covered one time per year. BILL ON CODE D1110</p> <p><u>Age 21 & Older with Special Needs:</u> Covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition or a pregnant woman. See also Debridement. (NE Medicaid covers one full mouth debridement procedure (maximum 1) and one prophylaxis procedure per quadrant (maximum of 4) for clients that have special needs.)</p> |
| D1120 | Prophylaxis – child (age 13 and younger) | \$22.00 | No | <u>Age 13 & Younger:</u> Covered at the frequency determined appropriate by the treating dentist with a 6 month prophylaxis considered the standard. BILL ON CODE D1120. |
| D1206 | Topical application of fluoride varnish | \$19.15 | No | |
| D1208 | Topical application of fluoride-excluding varnish | \$17.27 | No | |
| D1351 | Sealant – per tooth | \$25.00 | No | Covered on permanent and primary teeth, children and adults. A re-seal is not covered more often than every 2 years. |
| D1510 | Space maintainer – fixed unilateral | \$110.00 | No | Covered for clients age 20 and younger. |
| D1515 | Space maintainer – fixed – bilateral | \$190.00 | No | |
| D1550 | Recement or re- bond of space maintainer | \$21.00 | No | |
| D1555 | Removal of fixed space maintainer | \$21.00 | No | |

RESTORATIVE:

- A. Operative dentistry fee - includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately
- B. Resin - refers to a broad category of materials including but not limited to composites, and glass ionomers.
- C. Full Labial veneers- not covered for cosmetic purposes.
- D. Documentation of carious lesions must be present.
- E. A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.

The D2999 code is used for procedures that are not adequately described by a code, miscellaneous codes may not be used to claim an item that Medicaid doesn't cover.

Miscellaneous codes may not be used to claim an item that Medicaid doesn't cover.

| CODE | DESCRIPTION | FEE | PA* | COVERAGE CRITERIA/LIMITATIONS |
|---|---|---------|-----|---|
| <u>AMALGAM RESTORATIONS:</u> | | | | |
| D2140 | Amalgam – one surface, primary | \$50.00 | No | Primary teeth A – T |
| D2150 | Amalgam – two surfaces, primary | \$59.00 | No | |
| D2160 | Amalgam – three surfaces, primary | \$71.00 | No | |
| D2161 | Amalgam – four or more surfaces, primary | \$71.00 | No | |
| D2140 | Amalgam – one surface, permanent | \$50.00 | No | Permanent Teeth – 1 – 32 |
| D2150 | Amalgam – two surfaces, permanent | \$59.00 | No | |
| D2160 | Amalgam – three surfaces, permanent | \$71.00 | No | |
| D2161 | Amalgam – four or more surfaces, permanent | \$81.00 | No | |
| <u>RESIN-BASED COMPOSITE RESTORATIONS:</u> | | | | |
| D2330 | Resin-based composite – one surface, anterior | \$58.00 | No | <u>Primary</u> tooth numbers for anterior restorations – C – H, M – R <u>Permanent</u> tooth numbers for anterior restorations – 6 – 11, 22 - 27 |
| D2331 | Resin-based composite – two surfaces, anterior | \$72.00 | No | |
| D2332 | Resin based composite – three surfaces, anterior | \$83.00 | No | |
| D2335 | Resin based composite – four or more surfaces or involving incisal-angle (anterior) | \$97.00 | No | |
| D2391 | Resin-based composite – one surface posterior, permanent | \$59.00 | No | Primary tooth numbers for posterior composite |

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|-------------|---|------------|------------|---|
| D2392 | Resin-based composite – two surfaces, posterior | \$75.00 | No | restorations – A, B, I, J, K, L, S, T |
| D2393 | Permanent resin-based composite – three surfaces, posterior, | \$87.00 | No | |
| D2394 | Permanent resin-based composite – four or more surfaces, posterior, permanent | \$92.00 | No | |
| D2391 | Resin-based composite – one surface posterior, permanent | \$59.00 | No | Permanent tooth numbers for posterior composite restorations – 1 – 5, 12 – 16, 17 – 21, 28 - 32 |
| D2392 | Resin-based composite – two surfaces, posterior, permanent | \$75.00 | No | |
| D2393 | Resin-based composite – three surfaces, posterior permanent | \$87.00 | No | |
| D2394 | Resin-based composite – four or more surfaces, posterior, permanent | \$97.00 | No | |
| D2710 | Crown - resin – based composite (indirect) | \$194.00 | Yes | Submit x-rays with an ADA claim form prior authorization request Covered for anterior and bicuspid teeth when conventional restoration is not possible. Covered for molar teeth that have been endodontically treated that cannot be adequately restored with a stainless steel crown, amalgam or resin restoration. Must submit post endo xray with request. |
| D2720 | Crown - resin with high noble metal | \$330.00 | Yes | |
| D2721 | Crown – resin with predominantly base metal | \$329.00 | Yes | |
| D2722 | Crown – resin with noble metal | \$329.00 | Yes | |
| D2740 | Crown – porcelain/ceramic substrate | \$330.00 | Yes | |
| D2750 | Crown – porcelain fused to high noble metal | \$330.00 | Yes | |
| D2751 | Crown porcelain fused to predominantly base metal | \$330.00 | Yes | |
| D2752 | Crown – porcelain fused to noble metal | \$330.00 | Yes | |
| D2790 | Crown – full cast high noble metal | \$330.00 | Yes | |
| D2791 | Crown – full cast predominantly base metal | \$330.00 | Yes | |
| D2792 | Crown – full cast noble metal | \$330.00 | | |

| CODE | DESCRIPTION | FEE | PA* | COVERAGE CRITERIA/LIMITATIONS |
|-----------------------------|---|----------|-----|---|
| OTHER RESTORITIVE SERVICES: | | | | |
| D2910 | Recement or bond inlay, onlay, veneer or partial coverage restoration | \$20.00 | No | |
| D2915 | Recement or bond indirectly fabricated or | \$38.00 | No | |
| D2920 | Prefabricated post and core recement or bond crown | \$20.00 | No | |
| D2930 | Prefabricated stainless steel crown – primary tooth | \$116.00 | No | |
| D2931 | Prefabricated stainless steel crown – permanent tooth | \$116.00 | No | |
| D2932 | Prefabricated resin crown | \$103.00 | No | |
| D2933 | Prefabricated stainless steel crown with resin window | \$134.00 | No | Primary tooth |
| D2934 | Prefabricated esthetic coated stainless steel crown | \$134.00 | No | |
| D2940 | Protective restoration | \$32.00 | No | |
| D2950 | Core buildup, including any pins | \$73.00 | No | |
| D2951 | Pin retention – per tooth, in addition to restoration | \$11.00 | No | |
| D2954 | Prefabricated post and core in addition to crown | \$94.00 | No | |
| D2970 | Temporary crown (fractured tooth) | \$73.00 | No | |
| D2980 | Crown repair, by report | BR | No | A description of treatment provided must be submitted on or in the dental claim. This service is reviewed prior to payment. |
| D2999 | Unspecified restorative procedure, by report | BR | No | |
| | | | | |

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|---------------------------|--|------------|------------|--|
| <u>ENDODONTICS</u> | | | | |
| D3220 | Therapeutic pulpotomy (excluding final restoration) | \$70.00 | No | Covered for primary teeth. Not covered for permanent teeth. |
| D3230 | Pulpal therapy (resorbable filling) – anterior primary tooth (excluding final restoration) | \$85.00 | No | |
| D3240 | Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) | \$90.00 | No | |
| D3310 | Root canal therapy – anterior (excluding final restoration) | \$243.00 | No | Covered for permanent teeth. <u>Age 19 & older:</u> Not covered for maxillary 2 nd molar if 1 st molar is in occlusion. |
| D3320 | Root canal therapy – bicuspid (excluding final restoration) | \$251.00 | No | |
| D3330 | Root canal therapy – molar (excluding final restoration) | \$334.00 | No | |
| D3346 | Retreatment of previous root canal therapy – anterior | \$221.00 | No | |
| D3347 | Retreatment of previous root canal therapy – bicuspid | \$251.00 | No | |
| D3348 | Retreatment of previous root canal therapy - molar | \$334.00 | No | |
| D3351 | Apexification/recalcification | \$88.00 | No | |
| D3410 | Apicoectomy | \$171.00 | No | Covered on permanent anterior teeth. |
| D3999 | Unspecified endodontic procedure | \$40.00 | No | Covered for emergency treatment to relieve endodontic pain. Include the tooth number on the claim. |

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|-----------------------------|---|------------|------------|---|
| <u>PERIODONTICS:</u> | | | | |
| D4210 | Gingivectomy or Gingivoplasty – four or more contiguous teeth or bonded teeth spaces per quadrant | \$94.00 | No | |
| D4211 | Gingivectomy or Gingivoplasty – one to three contiguous teeth or bonded teeth spaces per quadrant | \$71.00 | No | |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant | \$100.00 | Yes | <u>Submit with PA request:</u> 1. PA x-rays 2. Perio charting 3. Health history & medical information about the client 4. Length of time they have been patient in your office An established patient is defined as a patient that has been seen in the dental office for two consecutive yearly recall appointments. |
| D4342 | Periodontal scaling and root planing – one to three teeth per quadrant | \$52.00 | Yes | |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | \$56.00 | No | <u>Covered in addition to a prophylaxis procedure.</u> (See page 4) <u>Clients with special needs:</u> Cover one-D4355, (maximum of 1) and one prophylaxis procedure <u>per-quadrant</u> (maximum of 4) for clients that have special needs. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition, or clients that must be treated in a hospital outpatient or Ambulatory Surgical Center setting. |
| D4910 | Periodontal maintenance | \$29.00 | Yes | <u>Submit with ADA claim form prior authorization request:</u> 1. Date scaling & root planing completed. 2. Health history & medical information about the client. 3. Frequency client must be seen for maintenance procedure |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|---|---|----------------------|------------|---|
| | | | | <p>Covered for clients that have had periodontal scaling & root planing, and are compliant with home care within their abilities.</p> <p>Must submit annual prior authorization request to continue billing.</p> |
| <p><u>PROSTHODONTICS (REMOVABLE):</u></p> <p>A. A complete prosthetic appliance case includes all materials and necessary adjustments for a period of six months following placement of the prosthesis.</p> <p>B. Tissue conditioning is covered one time during the first six months following the placement of the prosthesis. (See D5850 and D5851.)</p> <p>Covered every 5 years, with a 1 time replacement for broken/lost/stolen. Needs Prior Authorization.</p> <p>C. Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five years.</p> | | | | |
| D5110 D5120 | Complete denture – maxillary Complete denture - mandibular | \$647.78 \$647.78 | Yes Yes | <p>Covered 6 months after extractions/interim denture (D5810 and D5811) or as replacement of existing denture that is no longer wearable and cannot be made wearable.</p> <p>Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis</p> <p>Submit with ADA claim form prior authorization request:</p> <ol style="list-style-type: none"> 1. Date of previous denture placement 2. Information on condition of existing denture. |
| D5130 D5140 | Immediate denture – maxillary Immediate denture - mandibular | \$538.00 \$538.00 | No No | <p>Considered a permanent denture. Covered one time.</p> <p>Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.</p> |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|---|---|------------|------------|---|
| <u>PARTIAL DENTURES:</u> A. (Codes D5211, D5212, D5213, D5214) Covered if client does not have adequate occlusion. B. Adequate occlusion is defined as 1 st molar to 1 st molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. One to three missing anterior teeth should be replaced with a flipper partial (D5820 and D5821). *** <u>Note:</u> First tooth \$75.00, each additional tooth \$28.00 | | | | |
| D5211 | Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with resin or wrought wire clasps | \$453.93 | Yes | Submit with ADA claim form prior authorization request: 1. Chart or list missing teeth. 2. Provide age of any existing partial and condition of that partial 3. X-rays of remaining teeth. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis. |
| D5212 | Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) Includes acrylic resin base denture or wrought wire clasps | \$453.93 | Yes | |
| D5213 | Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$472.00 | No | <u>Coverage limited to clients age 20 and younger.</u> Replaced one time if lost or broken. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis. |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$472.00 | No | |
| D5410 | Adjust complete denture – maxillary | \$20.00 | No | Not covered for 6 months following placement of a new prosthesis. After 6 months covered as needed to make prosthetic appliance wearable. |
| D5411 | Adjust complete denture – mandibular | \$20.00 | No | |
| D5421 | Adjust partial denture – maxillary | \$20.00 | No | |
| D5422 | Adjust partial denture – mandibular | \$20.00 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|--------------------|---|-------------------|-------------------|--|
| D5510 | Repair broken complete denture base | \$94.00 | No | Covered as needed to make existing prosthetic appliance wearable. |
| D5520 | Replace missing or broken teeth – complete denture (each tooth) | ***Note | No | |
| D5610 | Repair resin denture base | \$94.00 | No | |
| D5620 | Repair cast framework | \$108.00 | No | Covered as needed to make existing prosthetic appliance wearable. |
| D5630 | Repair or replace broken clasp | \$108.00 | No | |
| D5640 | Replace broken teeth – per tooth | ***Note | No | |
| D5650 | Add tooth to existing partial denture | ***Note | No | |
| D5660 | Add clasp to existing partial denture | \$103.00 | No | |
| D5710 | Rebase complete maxillary denture | \$185.00 | No | Not covered for 6 months following the placement of a new prosthesis. After 6 months, covered as needed to make existing prosthetic appliance wearable. |
| D5711 | Rebase complete mandibular denture | \$185.00 | No | |
| D5720 | Rebase maxillary partial denture | \$185.00 | No | |
| D5721 | Rebase mandibular partial denture | \$185.00 | No | |
| D5730 | Reline complete maxillary denture (chair side) | \$94.00 | No | After 6 months, covered as needed to make existing prosthetic appliance wearable. During the first 6 month period, following placement of a prosthetic appliance, tissue conditioning (D5850 & D5851) are covered. (See page 11 of 17). |
| D5731 | Reline complete mandibular denture (chair side) | \$94.00 | No | |
| D5740 | Reline maxillary partial denture (chair side) | \$94.00 | No | |
| D5741 | Reline mandibular partial denture (chair side) | \$94.00 | No | |
| D5750 | Reline complete maxillary denture (laboratory) | \$156.00 | No | |
| D5751 | Reline complete mandibular denture (laboratory) | \$156.00 | No | |
| D5760 | Reline maxillary partial denture (laboratory) | \$156.00 | No | |
| D5761 | Reline mandibular partial denture (laboratory) | \$156.00 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|---|--|-------------------|-------------------|---|
| D5810 | Interim complete denture (maxillary) | \$349.00 | No | Can be replaced with a complete denture 6 months |
| D5811 | Interim complete denture (mandibular) | \$349.00 | No | after placement of the interim denture. Complete dentures require prior authorization. (See page 8). Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis. |
| D5820 | Interim partial denture (maxillary) (flipper partial) | \$236.00 | Yes | Considered a permanent replacement for 1 to 3 missing anterior teeth. |
| D5821 | Interim partial denture (mandibular) (flipper partial) | \$236.00 | Yes | Not covered for temporary replacement of missing teeth Relines, rebases and adjustment are not covered for 6 months after placement of the prosthesis. Submit with PA request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of existing partials. 3. Information on condition of existing partial. |
| D5850 | Tissue conditioning, maxillary | \$43.00 | No | Covered one time during the first 6 months following placement of prosthesis. Covered at other times with documentation of medical necessity. |
| D5851 | Tissue conditioning, mandibular | \$43.00 | No | |
| D6930 | Re-cement or bond fixed partial denture | \$42.00 | No | |
| <u>ORAL AND MAXILLOFACIAL SURGERY:</u> | | | | |
| D7111 | Extraction, coronal remnants – deciduous tooth (A – T)(Primary Teeth only) | \$44.00 | No | Extractions are covered when there is documented medical need in the dental chart for the extraction. |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (A – T) (1 – 32)(Primary and Permanent Teeth) | \$59.00 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|--------------------|---|-------------------|-------------------|--|
| D7210 | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. | \$93.00 | No | The Medicaid fee for extractions includes local anesthesia, suturing If needed, and routine postoperative care. (See 471 NAC 6-005, Page 9 of 14) |
| D7220 | Removal of impacted tooth – soft tissue | \$122.00 | No | |
| D7230 | Removal of impacted tooth – partially bony | \$167.00 | No | |
| D7240 | Removal of impacted tooth – completely bony | \$202.00 | No | |
| D7241 | Removal of impacted tooth – completely bony, unusual surgical complications | \$212.00 | No | |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | \$88.00 | No | |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus | \$150.00 | No | |
| D7280 | Surgical access of an unerupted tooth (permanent teeth only) | \$140.00 | No | |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | \$114.00 | No | |
| D7283 | Placement of device to facilitate eruption of impacted tooth (permanent teeth only) | \$135.00 | No | |
| D7285 | Incisional biopsy of oral tissue – hard (bone, tooth) | \$94.00 | No | The Medicaid fee is for the professional component only. |
| D7286 | Incisional biopsy of oral tissue – soft | \$85.00 | No | The lab must bill the specimen charge. |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant | \$88.00 | No | The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | \$71.00 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|--------------------|--|-------------------|-------------------|--|
| D7320 | Alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces per quadrant | \$94.00 | No | Alveoloplasty is a separate billable procedure. D7310 and D7311 are covered when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance. |
| D7321 | Alveoloplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant | \$76.00 | No | |
| D7410 | Radical excision – lesion diameter up to 1.25 cm | BR | No | |
| D7411 | Excision of benign lesion greater than 1.25 cm | BR | No | |
| D7412 | Excision of benign lesion, complicated | BR | No | |
| D7413 | Excision of malignant lesion up to 1.25 cm | BR | No | |
| D7414 | Excision of malignant lesion, greater than 1.25 cm | BR | No | |
| D7415 | Excision of malignant lesion, complicated | BR | No | |
| D7440 | Excision of malignant tumor – lesion diameter up to 1.25 cm | BR | No | |
| D7441 | Excision of malignant tumor – lesion diameter greater than 1.25 cm | BR | No | |
| D7450 | Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm | BR | No | |
| D7451 | Removal of benign odontogenic cyst or tumor – lesion diam. greater than 1.25 cm | BR | No | |
| D7460 | Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm | BR | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|-------------|--|------------|------------|---|
| D7461 | Removal of benign nonodontogenic cyst or tumor – lesion diam. greater than 1.25 cm | BR | No | |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report | BR | No | |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | \$110.00 | No | |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | \$42.00 | No | |
| D7880 | Occlusal orthotic device, by report | BR | No | <p>Occlusal orthotic devices are defined as splints that are provided for treatment of temporomandibular joint dysfunction. The fee includes any necessary adjustments. Document the type of appliance made and medical condition on or in the claim.</p> <p>For treatment of bruxism or for minor occlusal problems, see D9940. (See page 17 of 17).</p> |
| D7960 | Frenulectomy (frenectomy or frenotomy) – separate procedure | \$92.00 | No | |

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|---|--|---|------------|---|
| <u>ORTHODONTICS:</u> | | | | |
| A. Orthodontic treatment is covered for clients age 20 and younger when determined to have a handicapping malocclusion by a Medicaid Dental Consultant. Orthodontic codes restricted to age 20 and younger are D8060 – D8999. | | | | |
| B. | | | | |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | Fee deter- mined by treatment | Yes | See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment |
| | <u>Procedures covered under code D8060</u> | | | Required Documentation: Submit: ADA claim form prior authorization request. Interceptive Treatment Ortho form X-rays/photos |
| | Chrome steel wire clasps-each .036 or minimum .030 | \$21.00 | Yes | |
| | Inclined plane (hawley) appliance, bite plane, with clasps | \$156.00 | Yes | |
| | Cross-bite appliance, anterior, acrylic | \$129.00 | Yes | |
| | Cross-bite appliance, posterior, two bands plus attachments | \$129.00 | Yes | |
| | Attachment springs for any orthodontic or pedodontic appliance – each | \$21.00 | Yes | |
| | Adjustment of pedodontic and interceptive orthodontic appliances (allowed one per month) | \$17.00 | Yes | |
| | Space maintainer – fixed – unilateral, part of interceptive orthodontic treatment plan | \$110.00 | Yes | |
| | • Space maintainer – fixed – bilateral, part of interceptive orthodontic treatment plan | \$190.00 | Yes | |
| D8090 | Comprehensive orthodontic treatment of the adult dentition | Fee deter- mined by treatment plan | Yes | See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment. |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|-------------|--|------------|------------|--|
| | <u>Procedures covered under code D8090:</u> <ul style="list-style-type: none"> Constructing and placing fixed maxillary appliance, active treatment | \$350.00 | Yes | |
| | <ul style="list-style-type: none"> Constructing and placing fixed mandibular appliance, active treatment | \$350.00 | Yes | ADA claim form prior authorization request. HLD Index form Oral facial Full mouth and/or Panoramic Cephalometric Models or digital model photos Narrative description of the diagnosis |
| | Each one month period of active treatment – maxillary arch | \$35.00 | Yes | |
| | Each one month period of active treatment – maxillary arch, unusual service (surgical correction case) | \$51.00 | Yes | |
| | Each one month period of active treatment – mandibular arch | \$35.00 | Yes | |
| | Each one month period of active treatment – mandibular arch, unusual service (surgical correction case) | \$51.00 | Yes | |
| | Retainer or retention appliance | \$95.00 | Yes | |
| | Each one-month period of retention appliance | \$19.00 | Yes | |
| | Treatment, maxillary arch | \$19.00 | Yes | |
| | Each one-month period of retention appliance treatment, mandibular arch | \$19.00 | Yes | |
| | Rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance | \$178.00 | Yes | (Comprehensive orthodontic treatment continued.) |
| | Herbst appliance | \$270.00 | Yes | |
| | Protraction facemask | \$162.00 | Yes | |
| | Slow expansion appliance | \$177.00 | Yes | |
| | <ul style="list-style-type: none"> Headgear | \$162.00 | Yes | |
| | Inclined plane (hawley) appliance, bite plane, with clasps | \$156.00 | Yes | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|-------------|--|------------|------------|---|
| | Orthodontic appliance not listed | BR | Yes | |
| | • Orthodontic procedure not listed | BR | Yes | |
| | Space maintainer – fixed – unilateral, part of comprehensive orthodontic treatment plan | \$110.00 | Yes | |
| | • Space maintainer – fixed – bilateral, part of comprehensive orthodontic treatment plan | \$190.00 | Yes | |
| D8210 | Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting) | \$150.00 | No | |
| D8220 | Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting) | \$206.00 | No | |
| D8691 | Repair of orthodontic appliance | BR | No | Include a description of the repair on or in the claim. |
| D8692 | Replacement of lost or broken retainer | \$95.00 | No | Covered if the client is compliant with wearing the appliance. |
| D8999 | Unspecified orthodontic procedure, by report | BR | No | Billable for repairs associated with orthodontic treatment when repairs exceed routine repairs associated with orthodontic treatment. Include a description of the repair on or in the claim. |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|--|---|------------|------------|--|
| <u>ADJUNCTIVE GENERAL SERVICES:</u> | | | | |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure | \$23.00 | No | Examples: treatment of soft tissue infections, smoothing a fractured tooth. Include a description of the treatment on or in the claim. |
| D9220 | General anesthesia – first 30 minutes | \$162.00 | No | Covered when it is medically necessary to treat the client. |
| D9221 | Deep sedation/general anesthesia – each additional 15 minutes | \$81.00 | No | |
| D9230 | Analgesia, anxiolysis, inhalation of nitrous oxide | \$26.49 | No | |

| <u>CODE</u> | <u>DESCRIPTION</u> | <u>FEE</u> | <u>PA*</u> | <u>COVERAGE CRITERIA/LIMITATIONS</u> |
|-------------|--|------------|------------|--|
| D9241 | Intravenous moderate (conscious) sedation/analgesia – first 30 minutes | \$94.00 | No | Document the medical need in the dental chart. |
| D9242 | Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes | \$43.00 | No | |
| D9248 | Non-intravenous moderate (conscious) sedation | \$150.00 | No | |
| D9410 | House/extended care facility | \$35.00 | No | Cover <u>one per day per facility</u> |
| D9420 | Hospital call | \$80.00 | No | Regardless of the number of patients seen. Document on or in the claim the name of the facility, or home address where treatment was provided. |
| D9440 | Office visit – after regularly scheduled hours | \$45.00 | No | Covered in addition to exam and treatment provided when treatment is provided after dental office normal office hours. |
| D9940 | Occlusal guard | \$164.00 | No | Covered to minimize the effects of bruxism and other occlusal factors. Occlusal guards are defined as removable appliances. Document the medical need in the dental chart. Does not cover Athletic guard. |